STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	05/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT STREET GARY, IN46404

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F0000	This visit was for the Investigation of Complaints IN00090131 and IN00090300. Complaint number IN00090131 substantiated no deficiencies related to the allegations are cited. Complaint number IN00090300 substantiated, Federal/State deficiencies related to the allegations are cited at F 223 F 225, F 226, F 279, and F 323. Survey dates: May 16 and 17, 2011 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 128 Total: 128 Census payor type: Medicare: 22 Medicaid: 95 Other: 11 Total: 128 Sample: 10	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 5-20-11 Cathy Emswiller RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview the facility failed to ensure a resident was free from physical abuse for 1 or 2 residents reviewed for allegations of abuse in a sample of 10 related to CNA #1 pushing the resident into a chair and the chair sliding back to the wall with CNA #2 and CNA #3 in the room and failed to intervene to protect the resident. (Resident #D, CNA #1, CNA #2, and CNA #3) Findings included: The record for Resident #D was reviewed on 5/16/11 at 11:20 a.m. Her diagnoses included, but were not limited to, hypertension, dementia with behaviors, anxiety, insomnia, and Alzheimer's	F0223	Allegation of Credible Compliance. This plan of correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed in this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliiance. #1 What corrective actions will be accomplished for those residents found to have been affected by the deficient	06/16/2011

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	Disease. A progress note dated 4/29/11 at 9:13 a.m., indicated resident was sitting in south dining room when staff member went to take another resident's tray. The resident thought staff member had said something to her when this resident got upset and jumped up and grab the staff member by her neck. The resident was immediately removed from staff and sat in chair. When nurse arrived in dining room resident was sitting in chair. The nurse offered resident to take a walk but resident refused. Resident indicated she just wanted to sit in the chair. Resident had no injury and resident was pleasant with staff and other residents at this time. Resident's family and physician made aware. A progress note dated 4/29/11 at 13:34 (1:34 p.m.), indicated nurse was told by staff there was an altercation between resident and staff. This incident was initiated by staff. Resident was relaxing in chair at this time. Body assessment done, no new injuries noted. No complaints of pain or discomfort. Resident alert and pleasant with staff and other residents. A reportable incident was provided by the Administrator and reviewed on 5/16/11 at		practice? Resident #D was assessed for injuries with no injuries noted. Social Service also assessed resident #D for any abnormal findings with psychosocial well being. No abnormal findings noted. Resident's #D primary doctor and family were notified of occurrence. ISDH, Adult Protective Services, and local police were also notified of occurrence. The certified nursing assistants, #1, #2, and #3 had all received training on the facility policy related to abuse and reporting of abuse. They were well aware of the facility policies and chose to violate those policies. The conduct of these individuals was absolutely unacceptable to Administration of this facility and CNA #1, #2 and #3 were terminated. #2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?As identified by facility policy, all residents have the right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, corporal punishment and misappropriateion of resident property. Thus, all residents have the potential to be affected by the same deficient practice. All residents will be interviewed and assessed for any verbal reports, signs, and symptoms of abuse. Any abnormal findings will be	

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	8:00 p.m. The incident involved Resident #D and CNA #1, CNA #2, and CNA #3. "On April 29, 2011, (CNA#1's name) reported to the nurse that at approximately 9:00 a.m., while assisting residents in the dining room, (Resident #D's name), had been swearing at her and became physically aggressive and grabbed her by the throat. The nurse assessed the situation and reported to management. We began an immediate investigations into the alleged resident to staff abuse and found that the staff member, (CNA #1's name), provoked the resident and that the resident, while going after (CNA #1's name), did not grab (CNA #1's name) by the throat. She seems to have been reacting to some conversation (CNA #1's name) was having with her. This was confirmed by video surveillance. Video surveillance also showed that (CNA #2's name), and (CNA #3's name) were present in the area and did not seek assistance or intervene in this situation. Based on our initial investigation, (CNA #1's name), (CNA #2's name), and (CNA #3's name) were suspended immediately pending further investigation. The physician and family were notified and the resident has no injuries." "(CNA #1, #2, and #3's name) have been terminated." There was no injury noted.		investigated and reported as required by ISDH guidelines. #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On 4/29/11 Nursing personnel were immediately inserviced on the facility abuse policy. On 5/3/11 additional inservices were held related to the facility abuse policy. The Ombudsman also provided inservices for staff related to resident rights and caring for residents with aggressive behaviors. A mandatory inservice for all staff will be given on identification of abuse and reporting of abuse. Inservice training will be completed no later than June 16, 2011. #4 How will the corrective actions be monitored to ensure the deficient practice will not recur? A Quality Assurance Audit Tool will be utilized by Social Services or Designee to audit for any reports of signs or symptoms of abuse from 5 resident per week for three months then 5 residents monthly, therafter. Any concerns will be reported to the administrator immediately for further investigation. Reports to ISDH will be made as required by regulations. Unit Managers/designee will select 5 staff members each week for 4 weeks and then 5 staff members monthly for 3 months on interviewing on abuse and reporting of abuse and quarterly	

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	The initial report indicated the incident date was April 29, 2011. "Staff member alleged that (Resident #D's name) grabbed her by the throat. However, during our immediate investigation CNA was observed handling treating resident in a rough and inappropriate manner while (CNA #2's name) and (CNA #3's name) were present in the area and witnessed the event. The staff noted above were all suspended pending outcome of investigation." A mood/behavior report sheet provided with the investigation which was completed by (CNA #1), indicated "I (CNA #1's name) was in the south dinning (sic) room picking up trays. I went to pick up a resident's name tray, and (Resident #D's name) said thank you. I said your welcome, and (Resident #D's name) started cursing me out. So I went to get the toul (sic) from a resident's name and that's when she (Resident #D's name) jumped up and grabbed me by the throat. When she did that I grabbed her hands and sat her in the chair. The nurse heard the noise and came right in to see what had happened. A Progressive Counseling and Corrective Actions form for CNA #1 indicated termination, date and time of occurrence:		thereafter. Findings of results will be submitted for Quality Assurance Review and any concerns addressed.	

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	4/29/11. Statement: allegation of abuse has been substantiated. A Progressive Counseling and Corrective Actions form for CNA #2 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. A Progressive Counseling and Corrective Actions form for CNA #3 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. The Abuse, Neglect, and Misappropriation of Resident Property Policy and Procedure was provided by the Administrator on 5/16/11 at 3:40 p.m. "This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated (sic) and federal regulations. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other			

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	individuals." "This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of all allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property. Definitions Abuse: "The willful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." Physical abuse: "Includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment." Interview with the Administrator on 5/16/11 at 12:55 a.m., indicated when she heard the allegations of Resident #D's behavior she thought something just was not right. She watched the surveillance video and saw what had happened. Resident #D spilled drink on pants. CNA #1 came over and there were words. CNA			

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	#1 walks away. CNA #1 was seen talking to CNA #2, and CNA #3 and she appeared on the tape to have an attitude. CNA #1 goes back to Resident #D and was pointing her finger at her. The resident pushed the hand away. All of this time there are words being said. Resident # D stands and reaches a hand out to grab CNA #1 at which time CNA #1 pushes the resident who falls back into her chair and the chair goes back against the wall. Interview with the Director of Nursing on 5/17/11 at 11:00 a.m., indicated she was very upset when she viewed the video tape. As soon as she saw the tape she indicated she wanted all three of the staff members out of the facility immediately. This Federal tag relates to Complaint IN00090300. 3.1-27(a)(1)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview the facility failed to immediately report physical abuse of a resident to the Administrator for 1 or 2 residents reviewed for allegations of abuse in a	F0225	#1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #D was assessed for injuries with no injuries noted. Social Service	06/16/2011

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	sample of 10 related to CNA #1 pushing the resident into a chair and the chair sliding back to the wall with CNA #2 and CNA #3 in the room failed to intervene to protect the resident. (Resident #D, CNA #1, CNA #2, and CNA #3) Findings included: The record for Resident #D was reviewed on 5/16/11 at 11:20 a.m. Her diagnoses included, but were not limited to, hypertension, dementia with behaviors, anxiety, insomnia, and Alzheimer's Disease. The quarterly Minimum Data Set Assessment dated 5/2/11, indicated the resident was understood and understands. She scored a 4 on her Brief Interview of Mental Status. This indicated the resident was severely impaired cognitively. A progress note dated 4/29/11 at 9:13 a.m., indicated resident was sitting in south dining room when staff member went to take another resident's tray. The resident thought staff member had said something to her when this resident got upset and jumped up and grab the staff member by her neck. The resident was immediately removed from staff and sat in chair. When nurse arrived in dining room resident was sitting in chair. The nurse		also assessed resident #D for any abnormal findings with psychosocial well being. No abnormal findings noted. Resident's #D primary doctor and family were notified of occurrence. ISDH, Adult Protective Services, and local police were also notified of occurrence. The certified nursing assistants, #1, #2, and #3 had all received training on the facility policy related to abuse and reporting of abuse. They were well aware of the facility policies and chose to violate those policies. The conduct of these individuals was absolutely unacceptable to Administration of this facility and CNA #1, #2 and #3 were terminated. #2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?As identified by facility policy, all residents have the right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, corporal punishment and misappropriateion of resident property. Thus, all residents have the potential to be affected by the same deficient practice. All residents will be interviewed and assessed for any verbal reports, signs, and symptoms of abuse. Any abnormal findings will be investigated and reported as required by ISDH guidelines. #3 What measures will be put into	

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	offered resident to take a walk but resident refused. Resident indicated she just wanted to sit in the chair. Resident had no injury and resident was pleasant with staff and other residents at this time. Resident's family and physician made aware. A progress note dated 4/29/11 at 13:34 (1:34 p.m.), indicated nurse was told by staff there was an altercation between resident and staff. This incident was initiated by staff. Resident was relaxing in chair at this time. Body assessment done, no new injuries noted. No complaints of pain or discomfort. Resident alert and pleasant with staff and other residents. A reportable incident was provided by the Administrator and reviewed on 5/16/11 at 8:00 p.m. The incident involved Resident #D and CNA #1, CNA #2, and CNA #3. "On April 29, 2011, (CNA#1's name) reported to the nurse that at approximately 9:00 a.m., while assisting residents in the dining room, (Resident #D's name), had been swearing at her and became physically aggressive and grabbed her by the throat. The nurse assessed the situation and reported to management. We began an immediate investigations into the alleged resident to staff abuse and		place or what systemic changes will be made to ensure that the deficient practice does not recur? On 4/29/11 Nursing personnel were immediately inserviced on the facility abuse policy. On 5/3/11 additional inservices were held related to the facility abuse policy. The Ombudsman also provided inservices for staff related to resident rights and caring for residents with aggressive behaviors. A mandatory inservice for all staff will be given on identification of abuse and reporting of abuse. Inservice training will be completed no later than June 16, 2011. #4 How will the corrective actions be monitored to ensure the deficient practice will not recur? A Quality Assurance Audit Tool will be utilized by Social Services or Designee to audit for any reports of signs or symptoms of abuse from 5 resident per week for three months then 5 residents monthly, therafter. Any concerns will be reported to the administrator immediately for further investigation. Reports to ISDH will be made as required by regulations. Unit Managers/designee will select 5 staff members each week for 4 weeks and then 5 staff members monthly for 3 months on interviewing on abuse and reporting of abuse and quarterly thereafter. Findings of results will be submitted for Quality Assurance Review and concerns	

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	found that the staff member, (CNA #1's name), provoked the resident and that the resident, while going after (CNA #1's name), did not grab (CNA #1's name) by the throat. She seems to have been reacting to some conversation (CNA #1's name) was having with her. This was confirmed by video surveillance. Video surveillance also showed that (CNA #2's name), and (CNA #3's name) were present in the area and did not seek assistance or intervene in this situation. Based on our initial investigation, (CNA #1's name), (CNA #2's name), and (CNA #3's name) were suspended immediately pending further investigation. The physician and family were notified and the resident has no injuries." "(CNA #1, #2, and #3's name) have been terminated." There was no injury noted. The initial report indicated the incident date was April 29, 2011. "Staff member alleged that (Resident #D's name) grabbed her by the throat. However, during our immediate investigation CNA was observed handling treating resident in a rough and inappropriate manner while (CNA #2's name) and (CNA #3's name) were present in the area and witnessed the event. The staff noted above were all suspended pending outcome of investigation."		addressed.	

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	A mood/behavior report sheet provided with the investigation which was completed by CNA #1, indicated "I (CNA #1's name) was in the south dinning (sic) room picking up trays. I went to pick up a resident's name tray, and (Resident #D's name) said thank you. I said your welcome, and (Resident #D's name) started cursing me out. So I went to get the toul (sic) from a resident's name and that's when she (Resident #D's name) jumped up and grabbed me by the throat. When she did that I grabbed her hands and sat her in the chair. The nurse heard the noise and came right in to see what had happened. A counseling/Corrective Action Form dated 4/29/11 for CNA #2, indicated suspension pending abuse investigation. The associate comments: "refused to write statement." A counseling/Corrective Action Form dated 4/29/11 for CNA #3, indicated suspension pending abuse investigation. The associate comments: "refused to write statement." A Progressive Counseling and Corrective Actions form for CNA #1 indicated termination, date and time of occurrence: 4/29/11. Statement: allegation of abuse			

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	has been substantiated. A Progressive Counseling and Corrective Actions form for CNA #2 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. A Progressive Counseling and Corrective Actions form for CNA #3 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. The Abuse, Neglect, and Misappropriation of Resident Property Policy and Procedure was provided by the Administrator on 5/16/11 at 3:40 p.m. "This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated (sic) and federal regulations. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals."			

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	155580	A. BUILDING 00 B. WING	05/17/2011

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	"This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of all allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property. Definitions Abuse: "The willful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." Physical abuse: "Includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment." Policy Interpretation and Implementation included, but was not limited to, "the facility's will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with sate law through established procedures." When incidents involving suspected			

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	abuse, neglect or mistreatment including are reported, the facility shall take the following steps: "If resident sustains injury by an employee or employee is suspected perpetrator: remove the employee immediately. Staff is to notify immediate supervisor and he or she must conduct interview with employee and resident." Interview with the Administrator on 5/16/11 at 12:55 a.m., indicated when she heard the allegations of Resident #D's behavior she thought something just was not right. She watched the surveillance video and saw what had happened. Resident #D spilled drink on pants. CNA #1 came over and there were words. CNA #1 walks away. CNA #1 was seen talking to CNA #2, and CNA #3 and she appeared on the tape to have an attitude. CNA #1 goes back to Resident #D and was pointing her finger at her. The resident pushed the hand away. All of this time there are words being said. Resident # D stands and reaches a hand out to grab CNA #1 at which time CNA #1 pushes the resident who falls back into her chair and the chair goes back against the wall. It was further indicated that were CNA #2 and CNA #3 were interviewed in regard to the incident neither of the employees would say anything in regard to the incident.			

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	Interview with the Director of Nursing on 5/17/11 at 11:00 a.m., indicated she was very upset when she viewed the video tape. As soon as she saw the tape she indicated she wanted all three of the staff members out of the facility immediately. This Federal tag relates to Complaint IN00090300. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to implement its policy and procedure related to the reporting of abuse to the Administrator for 1 or 2 residents reviewed for allegations of abuse in a sample of 10 related to CNA #1 pushing the resident into a chair and the chair sliding back to the wall with CNA #2 and CNA #3 in the room and failed to intervene to protect the resident. (Resident #D, CNA #1, CNA #2, and CNA #3) Findings included: The record for Resident #D was reviewed	F0226	#1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #D was assessed for injuries with no injuries noted. Social Service also assessed resident #D for any abnormal findings with psychosocial well being. No abnormal findings noted. Resident's #D primary doctor and family were notified of occurrence. ISDH, Adult Protective Services, and local police were also notified of occurrence. The certified nursing assistants, #1, #2, and #3 had all received training on the facility policy related to abuse and reporting of abuse. They were	06/16/2011

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	on 5/16/11 at 11:20 a.m. Her diagnoses included, but were not limited to, hypertension, dementia with behaviors, anxiety, insomnia, and Alzheimer's Disease. The quarterly Minimum Data Set Assessment dated 5/2/11, indicated the resident was understood and understands. She scored a 4 on her Brief Interview of Mental Status. This indicated the resident was severely impaired cognitively. A progress note dated 4/29/11 at 9:13 a.m., indicated resident was sitting in south dining room when staff member went to take another resident's tray. The resident thought staff member had said something to her when this resident got upset and jumped up and grab the staff member by her neck. The resident was immediately removed from staff and sat in chair. When nurse arrived in dining room resident was sitting in chair. The nurse offered resident to take a walk but resident refused. Resident indicated she just wanted to sit in the chair. Resident had no injury and resident was pleasant with staff and other residents at this time. Resident's family and physician made aware. A progress note dated 4/29/11 at 13:34 (1:34 p.m.), indicated nurse was told by		well aware of the facility policies and chose to violate those policies. The conduct of these individuals was absolutely unacceptable to Administration of this facility. CNA #1, #2 and #3 were terminated. #2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?As identified by facility policy, all residents have the right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, corporal punishment and misappropriateion of resident property. Thus, all residents have the potential to be affected by the same deficient practice. All residents will be interviewed and assessed for any verbal reports, signs, and symptoms of abuse. Any abnormal findings will be investigated and reported as required by ISDH guidelines. #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On 4/29/11 Nursing personnel were immediately inserviced on the facility abuse policy. On 5/3/11 additional inservices were held related to the facility abuse policy. The Ombudsman also provided inservices for staff related to resident rights and caring for residents with aggressive behaviors. A mandatory inservice for all staff	

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	staff there was an altercation between resident and staff. This incident was initiated by staff. Resident was relaxing in chair at this time. Body assessment done, no new injuries noted. No complaints of pain or discomfort. Resident alert and pleasant with staff and other residents. A reportable incident was provided by the Administrator and reviewed on 5/16/11 at 8:00 p.m. The incident involved Resident #D and CNA #1, CNA #2, and CNA #3. "On April 29, 2011, (CNA#1's name) reported to the nurse that at approximately 9:00 a.m., while assisting residents in the dining room, (Resident #D's name), had been swearing at her and became physically aggressive and grabbed her by the throat. The nurse assessed the situation and reported to management. We began an immediate investigations into the alleged resident to staff abuse and found that the staff member, (CNA #1's name), provoked the resident and that the resident, while going after (CNA #1's name), did not grab (CNA #1's name) by the throat. She seems to have been reacting to some conversation (CNA #1's name) was having with her. This was confirmed by video surveillance. Video surveillance also showed that (CNA #2's name), and (CNA #3's name) were present		will be given on identification of abuse and reporting of abuse. Inservice training will be completed no later than June 16, 2011. #4 How will the corrective actions be monitored to ensure the deficient practice will not recur? A Quality Assurance Audit Tool will be utilized by Social Services or Designee to audit for any reports of signs or symptoms of abuse from 5 resident per week for three months then 5 residents monthly, therafter. Any concerns will be reported to the administrator immediately for further investigation. Reports to ISDH will be made as required by regulations. Unit Managers/designee will select 5 staff members each week for 4 weeks and then 5 staff members monthly for 3 months on interviewing on abuse and reporting of abuse and quarterly thereafter. Findings of results will be submitted for Quality Assurance Review and any concerns addressed.	

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	in the area and did not seek assistance or intervene in this situation. Based on our initial investigation, (CNA #1's name), (CNA #2's name), and (CNA #3's name) were suspended immediately pending further investigation. The physician and family were notified and the resident has no injuries." "(CNA #1, #2, and #3's name) have been terminated." There was no injury noted. The initial report indicated the incident date was April 29, 2011. "Staff member alleged that (Resident #D's name) grabbed her by the throat. However, during our immediate investigation CNA was observed handling treating resident in a rough and inappropriate manner while (CNA #2's name) and (CNA #3's name) were present in the area and witnessed the event. The staff noted above were all suspended pending outcome of investigation." A mood/behavior report sheet provided with the investigation which was completed by CNA #1, indicated "I (CNA #1's name) was in the south dinning (sic) room picking up trays. I went to pick up a resident's name tray, and (Resident #D's name) said thank you. I said your welcome, and (Resident #D's name) started cursing me out. So I went to get			

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	the toul (sic) from a resident's name and that's when she (Resident #D's name) jumped up and grabbed me by the throat. When she did that I grabbed her hands and sat her in the chair. The nurse heard the noise and came right in to see what had happened. A counseling/Corrective Action Form dated 4/29/11 for CNA #2, indicated suspension pending abuse investigation. The associate comments: "refused to write statement." A counseling/Corrective Action Form dated 4/29/11 for CNA #3, indicated suspension pending abuse investigation. The associate comments: "refused to write statement." A Progressive Counseling and Corrective Actions form for CNA #1 indicated termination, date and time of occurrence: 4/29/11. Statement: allegation of abuse has been substantiated. A Progressive Counseling and Corrective Actions form for CNA #2 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. A Progressive Counseling and Corrective			

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	Actions form for CNA #3 indicated a date and time of occurrence was 4/29/11. Statement: Termination for failing to intervene with patient abuse in the special care unit dining room. The Abuse, Neglect, and Misappropriation of Resident Property Policy and Procedure was provided by the Administrator on 5/16/11 at 3:40 p.m. "This facility's policy is that the resident has the right to be free from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated (sic) and federal regulations. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals." "This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of all allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property. Definitions Abuse: "The willful infliction of injury, unreasonable confinement, intimidations			

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	or punishment with resulting physical pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." Physical abuse: "Includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment." Policy Interpretation and Implementation included, but was not limited to, "The staff will not commit verbal, mental, sexual or physical abuse, including corporal punishment or involuntary seclusion." "The facility's will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with sate law through established procedures." When incidents involving suspected abuse, neglect or mistreatment including are reported, the facility shall take the following steps: "If resident sustains injury by an employee or employee is suspected perpetrator: remove the employee immediately. Staff is to notify immediate supervisor and he or she must			

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	conduct interview with employee and resident." Interview with the Administrator on 5/16/11 at 12:55 a.m., indicated when she heard the allegations of Resident #D's behavior she thought something just was not right. She watched the surveillance video and saw what had happened. Resident #D spilled drink on pants. CNA #1 came over and there were words. CNA #1 walks away. CNA #1 was seen talking to CNA #2, and CNA #3 and she appeared on the tape to have an attitude. CNA #1 goes back to Resident #D and was pointing her finger at her. The resident pushed the hand away. All of this time there are words being said. Resident # D stands and reaches a hand out to grab CNA #1 at which time CNA #1 pushes the resident who falls back into her chair and the chair goes back against the wall. It was further indicated that were CNA #2 and CNA #3 were interviewed in regard to the incident neither of the employees would say anything in regard to the incident. Interview with the Director of Nursing on 5/17/11 at 11:00 a.m., indicated she was very upset when she viewed the video tape. As soon as she saw the tape she indicated she wanted all three of the staff members out of the facility immediately.			

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	This Federal tag relates to Complaint IN00090300. 3.1-28(a)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to develop plans of care specific to the residents for 1 of 3 residents reviewed who were at risk for elopement in a sample of 10. (Resident #C) Findings include: The record for Resident #C was reviewed	F0279	#1 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The care plan for resident #C has been updated to reflect current needs of this resident. #2 How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The care plans for other residents who have been	06/16/2011

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	on 5/16/11 at 10:46 a.m. The resident's diagnoses included, but was not limited to, altered mental status, hypertension, dementia, and history of head trauma. Review of the quarterly Minimum Data Set Assessment dated 4/18/11, indicated the resident usually was understood and usually understands. He scored a 3 on his Brief Interview of Mental Status which indicated he was severely impaired cognitively. An elopement risk assessment dated 4/18/11, indicated he was at risk for elopement and was residing on the Special Care Unit. A progress note dated 5/8/11 at 22:42 (10:42 p.m.), indicated upon shift arrival and rounds, nurse and CNA noted resident in Special Care Unit ambulating up and down hallway. Visitors noted in Special Care Unit visiting other residents. Resident showed no signs of discomfort or distress. At 1700 (5:00 p.m.) nurse was notified of resident being outside in front of facility. Nurse noted resident outside walking calmly in front of facility's, no injuries or distress noted. Resident asked how did he get out here, resident stated, "I climbed out my window, I need to find Broadway st.," Nurse walked resident back in facility		assessed for high risk for elopement have been reviewed and updated. #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Based on elopement risk assessment triggers, careplan approaches will be reviewed and updated based on the resident's individual needs. Care plan reviewed quarterly and with any change in condition. #4 How will the corrective action be monitored to ensure the deficient practice does not recur? Elopement care plans will be reviewed and updated according to the MDS schedule at a minimum of quarterly. MDS coordinator/designee will review elopement care plans with Interdisciplinary Team at least quarterly. Results of the reviewed care plans will be forwarded to the Quality Assurance Committee and any concerns addressed.	

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	and to room to be assessed. No injuries noted and resident denied pain. All Special Care Unit windows were checked and all windows were locked. Resident placed on 15 minute checks. Physician made aware and no new orders. A care plan initiated on 5/9/11 indicated a focus of an elopement risk as evidenced by a history of wandering. The interventions was if resident was found to have wandered, place on 15 minute checks for 72 hours to ensure resident's safety. Interview with the Director of Nursing on 5/17/11 at 11:00 a.m., indicated the resident had been about a block from the facility. There was no further information provided in regards to a specific care plan for Resident #C in regards to his elopement. Federal tag relates to Complaint IN00090300. 3.1-35(a) 3.1-35(b)(1)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the	F0323	#1 What corrective action will be accomplished for those residents	06/16/2011

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	facility failed to ensure supervision was provided for 1 of 3 residents reviewed who were at risk for elopement in a sample of 10 related to a resident leaving the secured unit and being found outside of the facility. (Resident #C) Findings include: The record for Resident #C was reviewed on 5/16/11 at 10:46 a.m. The resident's diagnoses included, but was not limited to, altered mental status, hypertension, dementia, and history of head trauma. Review of the quarterly Minimum Data Set Assessment dated 4/18/11, indicated the resident usually was understood and usually understands. He scored a 3 on his Brief Interview of Mental Status which indicated he was severely impaired cognitively. An elopement risk assessment dated 4/18/11, indicated he was at risk for elopement and was residing on the Special Care Unit. A progress note dated 5/8/11 at 22:42 (10:42 p.m.), indicated upon shift arrival and rounds, nurse and CNA noted resident in Special Care Unit ambulating up and down hallway. Visitors noted in Special Care Unit visiting other residents.		found to have been affected by the deficient practice.Upon Resident #C's return to the facility he was immediately assessed with no injuries noted. Resident #C's family and physician were notified of occurrance.#2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. All facility windows were checked by maintenance personnel and the only issue identified was the screw for the window in which Resident #C climbed out of. This was fixed immediately. The facility has now installed metal bar with three screws in the bar to hold it in place. #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. An inservice was held with maintenance staff on preventative maintenace programs. The window inspection is on a monthly preventative maintenance program. Staff inservices to be held regarding appropriate interventions for residents who trigger for elopement on or before 6/16/11. Activity staff schedule was reviewed and ammended. #4 How will the corrective action be monitored to ensure the deficient practice does not recur?Window checks will be done monthly by	

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	155580	A. BUILDING 00 B. WING	05/17/2011

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	Resident showed no signs of discomfort or distress. At 1700 (5:00 p.m.) nurse was notified of resident being outside in front of facility. Nurse noted resident outside walking calmly in front of facility's, no injuries or distress noted. Resident asked how did he get out here, resident stated, "I climbed out my window, I need to find Broadway st.," Nurse walked resident back in facility and to room to be assessed. No injuries noted and resident denied pain. All Special Care Unit windows were checked and all windows were locked. Resident placed on 15 minute checks. Physician made aware and no new orders. The weather on was a high of 60 degrees and a low of 45 degrees with no precipitation. The back of the building has a fenced in area and some trees. The front of the facility has a packing lot and then goes to a side street with minimal traffic. A reportable incident was provided by the Administrator on 5/16/11 at 12:55 a.m. The incident occurred on 5/8/11. There was no injury. "Visitor/Family member called into facility's stating that our resident was walking outside on the sidewalk. Staff immediately ran outside and escorted resident back in the facility. When asked how he got outside he stated,		maintaince director/designee. Results will be shared in quality assurance meetings. Maintenance director/designee will submit monthly preventative maintenance to Administrator for verification of completion and any concerns addressed. Interventions to reduce elopement risk will be reviewed according to the MDS schedule by the Interdisciplinary team at a minimum of quarterly and any concerns will be forwarded to the QA committee for their review.	

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	"I went out of a window." Resident #C's name does reside on our Alzheimer's Unit. Video surveillance tape shows him attending activities throughout the day. The Staff on the special care unit were working as assigned and seen making routine rounds frequently throughout the day. Video shows Resident #C's name entering another resident's room. The other resident exits the room with no signs of distress. Resident #C's name does not leave that room. Video shows Resident #C's name returning with staff to the special care unit. A detailed time line of the video surveillance, indicated Resident #C entered another resident's room at 4:49 p.m. He was noted back on the unit at 5:11 p.m. Interview with the Administrator on 5/16/11 at 12:55 p.m., indicated the windows had a screw so that the window would only open four inches. Upon examination of all of the window in the special care unit it was found that the window in the room that Resident #C had entered had the screw bent. The			

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	Administrator further indicated that a metal bar had now been installed with three screw in the bar to hold it in place. She further indicated she was very thankful the family had called the facility. Interview with the Director of Nursing on 5/17/11 at 11:00 a.m., indicated the resident had been about a block from the facility. This Federal tag relates to Complaint IN00090300. 3.1-45(a)(2)			